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# Congruence of symptoms and sex-role expectations perceptions of male and female mental illness.

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CONGRUENCE OF SYMPTOMS AND SEX-ROLE EXPECTATIONS;  
PERCEPTIONS OF MALE AND FEMALE 'MENTAL ILLNESS'

by

Jodie Waisberg

B.Sc., University of Toronto, 1981

A Thesis

Submitted to the Faculty of Graduate Studies  
through the Department of Psychology  
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#### ABSTRACT

The primary purpose of this investigation was to test Rosenfield's (1982) hypothesis regarding reactions to mental illness. Rosenfield believes that such reactions are influenced by the extent to which a mentally ill individual deviates from his or her sex-role norms. Rosenfield has classified certain disorders as "masculine" and "feminine", based on their prevalence among the sexes and on the compatibility of their symptoms with behavioral expectations for the two sexes. A total of 235 subjects participated in the present study. Of these 235, 152 were undergraduate students at the University of Windsor, and 83 were psychologists registered in Ontario. Case histories describing people exhibiting symptoms of Alcohol Abuse, Antisocial Personality Disorder ("masculine disorders"), Major Depression, and Generalized Anxiety Disorder ("feminine disorders") were presented to the subjects. Subjects received either female, male or sex-unspecified case histories. Each case history was followed by a 7-item questionnaire, which measured the subjects' attitudes on the following variables concerning the individual described in the case history: degree of psychological disturbance; degree of responsibility for his or her behavior; degree of difference from the "average" person; usefulness of psychotherapy; usefulness of drug therapy; treatment recommendations; and prognosis. The main statistical analyses were analyses of variance, with Type of Disorder, Sex of Patient, and Sex of Subject as independent variables, and questionnaire ratings as dependent variables. Rosenfield's hypothesis was supported by the finding of a significant Sex of Patient by Type of Disorder interaction effect for psychologists' ratings of psychological

disturbance. Males with "feminine" disorders and females with "masculine" disorders were rated as more disturbed than their opposite sex counterparts. Two Sex of Subject effects in the psychologist sample were explored; these may reflect differences in the ways male and female psychologists view psychopathology in general. Several differences between the student and psychologist samples were examined and discussed. The roles of demographic variables in the two samples were also analyzed.

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## CHAPTER I

### INTRODUCTION

#### Double Standards

In 1970 Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel published a paper which sparked much research into the prevalence and implications of sexism in mental health fields. Broverman et al. gave three groups of clinicians questionnaires containing pairs of bipolar adjectives; at least one adjective in every pair had been previously found to be stereotypic of either men or women (Rosenkrantz, Vogel, Bee, Broverman, & Broverman, 1968). The clinicians were given the following instructions, with the words "male" and "female" inserted after "adult" in the instructions of the second and third groups of clinicians: "Think of normal adults and then indicate on each item the pole to which a mature, healthy, socially competent adult would be closer" (Broverman et al., 1970). Broverman et al. considered the responses to the "adult" (no sex specified) instructions to indicate "ideal" health patterns.

Subjects of both sexes rated the healthy, mature female very differently from the healthy, mature adult; they rated the healthy male similarly to the healthy adult. According to the clinicians' ratings, healthy women differ from healthy men by being "more submissive, less independent, less adventurous, more easily influenced, less aggressive, less competitive, more excitable in minor crises, more easily hurt, more emotional, more conceited about appearance, less objective and disliking math and science." The different concepts of health for men and women parallel societal sex-role stereotypes. Of the 38 stereotypic

items on the questionnaire, the masculine pole was viewed by college students as more socially desirable for 27 and the feminine pole as more socially desirable for the remaining 11 (Rosenkrantz et al., 1968). The clinicians indicated that 25 of the 27 male-valued items were more typical of healthy men than healthy women, and that seven of the 11 female-valued items were more typical of healthy women than healthy men. All but four of the socially desirable items were considered healthy for an adult. The four items on which there was disagreement between the clinicians' health ratings and the college students' social desirability ratings were: to be emotional; not to hide emotions; to be religious; and to have a very strong need for security. The first two were considered healthy for adults by clinicians, but not by students; the reverse was true of the last two items. Overall, then, the data support a relationship between professional concepts of mental health and social desirability as perceived by nonprofessionals.

Broverman suggested that a double standard of mental health for men and women exists and that it stems from an "adjustment" notion of health (Broverman et al., 1970). The double standard places females in a difficult situation, since it encourages them to accept behavioural norms for their sex, even though they are less socially desirable and considered less healthy for the generalized competent, mature adult.

#### Influence of Nonclinical Factors on Clinical Decision-Making

A fairly new body of literature exists which demonstrates the influence of social and attitudinal factors, many of which the clinician is unaware, on clinical decision-making. The results of some of these studies are provocative, as outlined below.

Mendel and Rapport (1969) analyzed 269 disposition decisions made

by psychologists, psychiatrists and social workers. They found that the decision to hospitalize was not related to severity of symptoms, but was related directly to whether the patient was previously hospitalized and inversely to the amount of clinical experience of the decision-maker. When asked, the clinicians stated that severity of symptoms was a major factor in their decisions, and previous hospitalization was not one.

Schwartz and Abramowitz (1975) presented psychiatrists with a case history of a person suffering from depression, somatic complaints, sexual conflicts and perfectionism. Sex and race of this person were varied. The psychiatrists rated the case histories on six dimensions--severity of maladjustment, prognosis, desirability of hospitalization, desirability of electroconvulsive therapy, desirability of pharmacotherapy, and desirability of insight-oriented therapy. The psychiatrists also completed a moral traditionalism scale. Schwartz and Abramowitz found no consistent psychiatric bias against blacks or females. However, the following differences were statistically significant: traditional psychiatrists recommended insight-oriented therapy more often for women than men, while nontraditional psychiatrists recommended it more often for men; the psychiatrists recommended therapy more often for white men than for black men; and they expressed a more optimistic prognosis for blacks.

In a study by Abramowitz, Abramowitz, Jackson, and Gomes (1973), non-liberal raters attributed more pathology to left-wing women than to left-wing men or politically neutral women who were otherwise identical. Thus, it is clear that there is much room for exploration of nonclinical factors which affect clinical judgments. The present study will attempt to examine the role of patient gender on the perception of his or her

condition by clinicians and laymen. An overview of the relevant research is presented below.

Research on Laymen's and Clinicians' Perceptions of Mentally Healthy Men and Women

Broverman, Vogel, Broverman, Clarkson, and Rosenkrantz (1972) reviewed the literature on sex-role perceptions up to 1972. They concluded that certain sex-role differences were considered healthy by mental health professionals and desirable by college students. These include positively valued masculine traits which entail competence, rationality and assertion, and positively valued feminine traits which reflect warmth and expressiveness. The Broverman et al. (1970) experiment was repeated by Nowacki and Poe (1973), who had introductory psychology students, rather than clinicians, serving as raters. They too found significant differences between their subjects' ratings of healthy men and women. Harris and Lucas (1976) repeated the Broverman et al. study, employing social work students as subjects. When comparing the scores of the total group of subjects, no statistically significant differences were found between scores for a healthy person and healthy male, scores for a healthy person and healthy female, or scores for a healthy male and healthy female. When the data were analyzed separately for male and female subjects, significant differences were found between ratings for a healthy man and a healthy woman. Male subjects rated a healthy man closer to the masculine pole than they rated a healthy woman. Female subjects did the reverse! They rated a healthy woman closer to the masculine pole than they rated a healthy man. In addition, female subjects rated a healthy person as more

masculine than males did.

Harris and Lucas suggest that their results differ from those of Broverman et al. (1970) and Nowacki and Poe (1973) for two reasons.

First, the feminist movement had a significant impact, particularly among university students, in the years between the earlier studies and theirs. Secondly, female graduate students comprised a large portion of the subjects in the Harris and Lucas research. This highly educated and career-oriented group may have been less likely to incorporate traditional sex-role stereotypes than were introductory psychology students. In fact, the graduate students may have been overly self-conscious about endorsing traditional stereotypes. Therefore, although Harris and Lucas's (1976) findings suggest a trend toward a more androgynous concept of health, these results may not be generalizable to the general population or to practising clinicians.

#### Reactions to Mentally Ill Men and Women

If a double standard of mental health does exist, it is important to discover what impact this has on the actual clinical and societal treatment of men and women. Tudor, Tudor, and Gove (1977) argued that men are judged more harshly than women for mental illness because their roles are more socially valuable. The disruption of a male's performance, according to Tudor et al., is more visible and is perceived as more threatening to the family. Tudor et al. present data to show that psychotic males are channelled into psychiatric treatment at an earlier age and that both psychotic and neurotic males are hospitalized for longer periods than are females. Rushing (1979) also asserts that society reacts more severely to mentally ill men than to



mentally ill women, and that this reaction varies because of the functional importance of their roles. He predicted that it is more important for middle-aged males--whose "functional importance" is greatest--than females to be admitted to hospital when emotionally disturbed and also to be released promptly so they can return to their more important roles. He presents data, which differ markedly from those of Tudor et al., to support this prediction. The conclusions of the above studies may be flawed; the studies' results may simply reflect real differences in the incidence and severity of psychiatric disorder, as opposed to differential societal reaction to male and female patients. As well, large diagnostic categories (severe/nonsevere; psychotic/neurotic) were used; this may have concealed important trends. Furthermore, the results of the Tudor et al. and Rushing studies are derived from data which were collected prior to the women's movement's time of strongest influence, and for this reason may have limited relevance today. At any rate, Tudor et al. and Rushing believe that men are judged more harshly for mental illness because they are a higher status group relative to women; while labeling theory would predict that those in lower status positions are more severely rejected.

Reactions to Specified Types of Disorders in Men and Women: "Deviant Deviance"

In a recent important study, Rosenfield (1982) analyzed data collected in a New York City hospital emergency room (ER). Rosenfield proposes that there are not more severe reactions to either males or females in general. According to her, both men and women receive a more severe reaction to their mental illness when the deviant behavior

is inconsistent with traditional sex role norms. Rosenfield used ER records completed by psychiatrists for 666 individuals who came to the ER in September and October of 1979. From these records Rosenfield gathered information on sex, diagnosis and disposition. Disposition included hospitalization (voluntary or involuntary) or nonhospitalization.

It is crucial to the interpretation of Rosenfield's results to note that more women than men suffer from neurosis and depression in both treatment and community populations, while more men suffer from personality disorders, and drug and alcohol abuse (Rosenfield, 1980; Dowrenwend & Dowrenwend, 1976; O'Grady, 1982; Weissman & Klerman, 1977). As well, the symptoms of the above categories are more consistent with feminine and masculine traditional roles, respectively. Depressed and neurotic people generally feel they lack control over their lives, they tend to be fearful and are usually self-critical. People with personality disorders and abusers of drugs and alcohol exhibit antisocial and aggressive symptoms more often than depressed or neurotic patients. Rosenfield believes that the symptomatology of schizophrenia is not relevant to expectations associated with either sex.

When she broke down the disorders to female-linked, male-linked and schizophrenia, Rosenfield's predictions were confirmed; that is, females were more likely to be hospitalized for personality disorders and substance abuse, males for neurosis and depression. Rosenfield holds that the differential probabilities of hospitalization are due to the degree of consistency of the deviant behavior with sex role norms. If behavior is more "unusual" it is seen as more problematic and provokes a more severe reaction, according to Rosenfield. The question of

whether Rosenfield's results are due to the psychiatrists' attitudes or to actual differences in the severity of the patients' disorders is difficult to answer. Severity is only grossly indicated in Rosenfield's data (e.g., neurotic or psychotic depression; alcohol intoxication or alcohol dependence). Furthermore, even if more precise ratings of severity had been given by the psychiatrists, these ratings too would be influenced by attitudinal factors if such factors do in fact have a significant impact upon clinicians' perceptions of patients. Rosenfield did examine the frequencies with which men and women were diagnosed as having neurotic and psychotic depression, and substance intoxication and dependence. She found that the differences in frequency were insufficient to explain the differential hospitalization rates.

Two studies which tend to support Rosenfield's hypothesis are Coie, Pennington, and Buckley's (1974) and Phillips's (1964). In the former the subjects were college students. They were given hypothetical cases in which the sex of the patient, the precipitating condition for his/her difficulties and the type of behavioral disorder were varied. Coie et al. found a "marginally significant" ( $p < .08$ ) interaction of sex by disorder, with greater disorder attributed to females for aggressive behavior and greater disorder attributed to males for somatic complaints. In contrast to Broverman's expectations of an overall bias against women, Coie et al. found no significant main effects for sex of patient on level of perceived psychological disorder or referral for professional help. Phillips (1964) presented case vignettes to 300 female subjects, who then completed a scale measuring their rejection of the patients in the case histories. The cases included people Phillips described as paranoid schizophrenic, depressed-neurotic, simple

schizophrenic and phobic-compulsive. Men were rejected more strongly than women. The results are not inconsistent with Rosenfield's, since by her classification scheme these cases are feminine or neutral. It would have been interesting to have had an aggressive behavior vignette in addition to the others.

Debliz (1979) carried out a study in which she examined reactions to case descriptions of male and female criminals with various mental disorders. She found that male raters viewed the labelled male psychopathic personality as more mentally ill than the labelled female, while male raters viewed the unlabelled female psychopathic personality as more mentally ill than the unlabelled male. The sex of the rater and the presence or absence of a diagnostic label significantly interacted with the criminal's sex. Male raters rated the male unlabelled anxiety neurotic as significantly more mentally ill than his female counterpart. As well, both male and female raters viewed the undiagnosed female anxiety neurotic as being less in need of hospitalization than the undiagnosed male or diagnosed female. These two findings, therefore, are also in agreement with Rosenfield's hypothesis.

A study which revealed no sex differences in ratings of severity of mental illness was that of Latorre (1975), who used case histories of obsessive-compulsive people and schizophrenic people with paranoid tendencies. However, these two disorders would be considered neither strongly masculine nor feminine by Rosenfield. Zeldow (1975) carried out two studies examining the effects of gender on clinical judgments. In the first he presented college students with Minnesota Multiphasic Personality Inventory (MMPI) statements attributed to psychiatric patients. He asked them to rate the degree of maladjustment of the

patients, based on the patients' statements. This study differs from other studies in that Zeldow used statements of feelings and beliefs rather than behavior of the patients to elicit ratings from his subjects. Judgments of emotional maladjustment were not influenced by the sex of the patient or the judge. In Zeldow's second study, he presented case descriptions to subjects who were more knowledgeable about psychology. He found no sex effects in this study either. With the exception of Zeldow's, the studies surveyed above generally support the notion that patient gender influences raters' judgments.

#### Sex of Rater Effects

Some studies have found that the sex of the rater influences his or her clinical judgments. Aslin (1977) repeated Broverman's study using male, female and feminist therapists as subjects. They were given Broverman's Sex-Role Stereotype Questionnaire and asked to rate either mentally healthy adults, females, wives or mothers. Feminist and female therapists differed from male therapists in their perceptions of health for mothers and females, but not for adults and wives. Haan and Livson (1973) found that male and female psychologists were more reactive to different traits in male and female patients, reflecting problem areas in the judges' perceptions of their own and opposite sex. They also found that male judges were harsher than female judges and that female judges were harsher to male subjects than to female subjects. Farina, Murray, and Groh (1978) found females to be more accepting than males of ex-mental patient job applicants. Broverman (1970) did not find sex of rater effects in her study. Zeldow (1976) found a significant three-way interaction between sex of judge, sex of

patient and type of statement (masculine or feminine) attributed to the psychiatric patient. He found that when a female patient expressed a masculine attitude, male laymen judged her more harshly than when the statement was feminine or neutral. No similar bias was found when the judge was female or the patient male. Latorre (1975) and Zeldow (1975) did not find sex of rater effects. The results surveyed above are contradictory, but indicate that sex of rater should be taken into account in the present study.

#### Statement of the Problem

The Broverman et al. study (1970) indicated that a double standard of mental health existed for men and women, and that the judgments of the clinician-subjects reflected stereotypes prevalent in their society. Dramatic changes in the roles of men and women have occurred since then, and these changes may have had an impact on definitions of mental health. As well, research efforts sparked by the Broverman et al. study have yielded conflicting results; some of them suggest that, while the sex of a mental patient influences professional and lay perceptions of that person, the biases are more complex and subtle than originally believed. The present study has attempted to add to the "social psychology of mental illness" literature by testing Rosenfield's hypothesis with both professional clinicians and university students serving as subjects.

The main purpose of the present study was to compare the reactions of both clinicians and laymen to case vignettes describing men and women alcoholics, psychopaths, depressives and anxiety neurotics. The study attempted to test Rosenfield's hypothesis. As stated earlier, Rosenfield (1982) believes that her data can be explained by proposing

differential societal reactions to mental illness, which are influenced by the degree to which the individual deviates from his or her sex-role norms. Alcoholism and psychopathy are more prevalent among men, and depression and anxiety are more prevalent among women. As well, the symptoms are more compatible with the behavioral expectations for the two sexes. Greenglass (1982) discusses how drinking, for example, is associated with virility in our culture. The drinking female is more subject to criticism than is the drinking male, and female alcoholism is more often hidden and untreated. While psychopathy is often characterized by aggressive behavior, depression is characterized by passivity and inactivity. Greenglass points out the parallels between the learned helplessness model of depression and female socialization and powerlessness. Anxiety disorders epitomize the so-called "emotionality" which women are often thought to possess more of than men.

Israel, Raskin, Libow, and Pravder (1978) carried out a study with aims related to the present one. Male and female undergraduate raters were presented with four case studies in which sex of client, sex-role appropriateness and mental disorder were manipulated. Significant interactions between sex-role appropriateness and both sex of client and sex of rater were found for several dependent variables. The results expected by Rosenfield's theory (i.e., that male depressives and female alcoholics would be viewed as more disturbed and requiring more intense treatment than their opposite sex counterparts) were not obtained. It is possible, however, that these results were not obtained because the male- and female-appropriate manipulations obscured them. It appears that each patient was portrayed as having

markedly masculine or feminine characteristics not directly resulting from the masculinity or femininity of his or her symptoms. Therefore, the effects of this manipulation could have confounded the gender-disorder interaction effects. To eliminate effects of sex-role deviation which are not directly related to the disorder, case descriptions in the present study included the symptoms necessary for diagnosis, and no other information related to sex-role appropriateness was presented. The raters' responses, therefore, should reflect their perceptions of the patient, especially with regard to the severity of the patient's condition, and their recommendations for treatment. It was thus possible to examine whether the sex-role appropriateness of the symptoms themselves influenced these judgments; Rosenfield's hypothesis would predict a Sex of Patient by Diagnosis interaction effect for ratings of disturbance and treatment. In addition, the effects and possible interactions of the rater's gender and professional status (clinician or undergraduate) were examined.

Although a case history study, such as the present one, cannot completely replicate actual clinical events, it may help us to better understand the processes whereby clinicians make diagnostic and other clinical judgments.



## CHAPTER II

### METHOD

#### Subjects

Subjects included undergraduate students at the University of Windsor and registered psychologists listed in the directory published by the Ontario Board of Examiners in Psychology. Three classes of undergraduate students, with 50 to 55 students in each class, participated: Their mean age was 20.2 years. Sixty-five were male and 87 were female. Approximately half were Social Science majors and half were not. One hundred and sixteen reported being born in North America, while 26 reported being born elsewhere. The remaining 10 did not report their places of birth. Of those reporting their year of study, 117 were in first year, 18 were in second year, five were in third year and two were in fourth year.

Letters were sent to 150 psychologists. Eighty-three letters were completed and returned. Forty-five psychologists indicated that they were male and 34 indicated that they were female. The mean age of the psychologist sample was 43.4 years.

#### Development of Case Histories and Questionnaires

Case histories (see Appendix A) of the type used by Debliz (1979) and Coie et al. (1974) were presented to the subjects. These case histories described people exhibiting symptoms of Alcohol Abuse, Antisocial Personality Disorder, Major Depression and Generalized Anxiety Disorder. The case histories were based primarily on information found in the DSM-III. They also incorporated information

from Shapiro (1965), Deblj (1979) and Phillips (1969). The case histories were in three forms--male, female, and sex unspecified. The wording of the sex-unspecified cases had to be modified slightly to facilitate the avoidance of personal pronouns.

Each case history was followed by a 7-item questionnaire, on which subjects expressed their attitudes using six 7-point scales and one 5-point scale (see Appendix B). The questionnaire measured the subjects' attitudes on the following variables concerning the individual described in each case history: degree of psychological disturbance; degree of responsibility for his or her behavior; degree of difference from the average person; usefulness of psychotherapy; usefulness of drug therapy; and prognosis. The question with a 5-point rating scale asked which of the following was the most appropriate course of action: let the person cope on his or her own; recommend rest and a change of pace; recommend counseling from a clergyman or family doctor; recommend treatment from a professional psychologist or psychiatrist; and recommend inpatient treatment in a hospital.

#### Procedure

Case descriptions and questionnaires were presented to the undergraduate students during their regular class meetings. Three daytime classes at the University of Windsor participated in the study. Case histories were presented without their diagnostic labels. One class was given the four female case histories, the second class was given the four male case histories, and the third class was given the four sex-unspecified case histories. The order of cases was randomized within conditions. The class which was given the male case histories

consisted of 25 male students and 25 female students; the class given the female cases consisted of 20 male students and 32 female students; and the class given the sex-unspecified cases consisted of 20 male students and 30 female students. All students were asked to complete the questionnaires at the time of their distribution. In addition, the third class was asked, after completing the questionnaire, to indicate to what sex they assumed the four people in the case histories to belong. The subjects were told that, if they wished, they could receive a letter describing the purpose and results of the study when such became available.

Case histories and questionnaires, along with a covering letter (see Appendix C), were sent to 150 registered psychologists. Only female and male case histories (no sex-unspecified case histories) were sent. Eighty-three letters were completed and returned. Twenty-four male psychologists and 13 female psychologists returned male case histories; and 21 male psychologists and 21 female psychologists returned female case histories.

### CHAPTER III

#### RESULTS

Data collected from the student and psychologist groups were analyzed separately. The main statistical analyses were univariate analyses of variance (ANOVA) on the dependent variables assessed by the questionnaires. These included ratings of psychological disturbance, appropriate treatment, difference from the average person, prognosis, patient's responsibility for the described behavior, usefulness of psychotherapy, and usefulness of drug therapy. Independent variables included Type of Disorder, Sex of Patient and Sex of Subject.

Additional ANOVAs were computed with demographic variables (major subject, year of study, place of birth) as the independent variables. Correlational analyses were carried out to examine the relationship between age and the questionnaire ratings listed above.

In addition, chi-square tests were used to analyze the students' guesses of the gender of patients with sex-unspecified case histories.

The significant results of this study are organized in the following sections: Psychologist Sample--(1) Type of Disorder Effects; (2) Sex of Subject Effects; (3) Sex of Subject by Type of Disorder Effects; (4) Sex of Patient by Type of Disorder Effect; (5) Demographic Variables. Student Sample--(1) Type of Disorder Effects; (2) Sex of Subject Effect; (3) Sex of Patient Effect; (4) Sex of Subject by Type of Disorder Effects; (5) Sex of Patient by Type of Disorder Effects; (6) Chi-square Analysis of Gender Guessing; and (7)

## Demographic Variables.

### Psychologist Sample

Seven analyses of variance (ANOVAs) were computed, one for each dependent variable assessed by the questionnaires. These were 4 (Type of Disorder) x 2 (Sex of Patient) x 2 (Sex of Subject) ANOVAs, with Type of Disorder as a within-subjects factor. The result of these ANOVAs are summarized in Table 1.

### Type of Disorder Effects

Type of Disorder main effects were found for all seven dependent variables. They can be summarized as follows: for ratings of psychological disturbance  $F(3,225) = 33.38, p < .0005$ ; for ratings of appropriate treatment  $F(3,224) = 17.53, p < .005$ ; for ratings of difference from the average person  $F(3,225) = 46.52, p < .0005$ ; for ratings of prognosis  $F(3,224) = 130.51, p < .0005$ ; for ratings of responsibility  $F(3,224) = 9.72, p < .0005$ ; for ratings of the usefulness of psychotherapy  $F(3,225) = 75.61, p < .0005$ ; and for ratings of the usefulness of drug therapy  $F(3,224) = 79.63, p < .0005$ . Mean ratings of the seven variables for the four diagnoses are presented in Table 2, along with the results of t-tests used to compare these means.

Psychological disturbance ratings were highest for individuals with Antisocial Personality Disorder and lowest for those with Generalized Anxiety Disorder. The Alcohol Abuse and Major Depression ratings were intermediate and did not differ significantly from one another. People with Antisocial Personality Disorder were rated as most different from the "average" person. The other ratings of difference from the "average" person, in decreasing order, were those of people suffering from Alcohol

Table 1

Summary of Significant Analyses of Variance Results for the PsychologistSample

Dependent variable	Source of variation	df	F
Ratings of psychological disturbance	Diag <sup>a</sup>	(3,225)	33.38**
	Sex P x Diag <sup>b</sup>	(3,225)	5.93**
Ratings of appropriate treatment	Diag	(3,224)	17.53**
Ratings of difference from the average person	Diag	(3,225)	46.52**
	Sex S x Diag <sup>c</sup>	(3,225)	3.88**
Ratings of prognosis	Sex S <sup>d</sup>	(1,75)	7.77**
	Diag	(3,224)	130.51**
Ratings of responsibility	Diag	(3,224)	9.72**
Ratings of usefulness of drug therapy	Sex S	(1,75)	8.22**
	Diag	(3,224)	79.63**
	Sex S x Diag	(3,224)	3.76*
Ratings of usefulness of psychotherapy	Diag	(3,225)	75.61**

<sup>a</sup> Diag refers to the Type of Disorder effect

<sup>b</sup> Sex P x Diag refers to the Sex of Patient by Type of Disorder interaction effect

<sup>c</sup> Sex S x Diag refers to the Sex of Subject by Type of Disorder interaction effect

<sup>d</sup> Sex S refers to the Sex of Subject effect

\*  $p < .05$

\*\*  $p < .01$

Table 2

Mean Psychologist Questionnaire Ratings According to Type of Disorder (N = 332)

Type of disorder	Ratings					
	Disturbance	Treatment	Difference	Prognosis*	Responsibility	Drug therapy Psycho- therapy
Major depression	4.95 <sup>B</sup>	4.01 <sup>B</sup>	4.91 <sup>C</sup>	1.86 <sup>C</sup>	4.11 <sup>B</sup>	4.49 <sup>A</sup> 5.74 <sup>A</sup>
Antisocial personality disorder	5.36 <sup>A</sup>	3.59 <sup>C</sup>	5.70 <sup>A</sup>	4.99 <sup>A</sup>	4.78 <sup>A</sup>	1.43 <sup>D</sup> 3.34 <sup>C</sup>
Alcohol abuse	5.03 <sup>B</sup>	4.41 <sup>A</sup>	5.26 <sup>B</sup>	2.97 <sup>B</sup>	4.81 <sup>A</sup>	2.90 <sup>C</sup> 4.74 <sup>B</sup>
Generalized anxiety disorder	4.22 <sup>C</sup>	3.96 <sup>B</sup>	4.19 <sup>D</sup>	2.08 <sup>C</sup>	4.33 <sup>B</sup>	3.72 <sup>B</sup> 5.86 <sup>A</sup>

Note. Means with the same letter are not significantly different from each other at the .05 level. "A" is the highest mean, "B" the second highest, "C" the third highest, and "D" the lowest.

\* The lower the prognosis score, the more optimistic is the prognosis.

Abuse, Major Depression, and Generalized Anxiety Disorder. The predicted outcome or prognoses of the depressed and anxious individuals were most optimistic, followed by those of the alcohol abusers and persons with Antisocial Personality Disorder, respectively. Recommendations for treatment varied as follows: The scores of alcohol abusers were highest (because inpatient treatment in a hospital, the highest rating on this scale, was recommended more often for alcohol abusers than for the other three types of patients); the scores of people with Antisocial Personality Disorder were lowest (because recommendations not involving professional psychological treatment were given more often for this group than for the other three); and the scores of the depressed and anxious people were intermediate and not significantly different from each other.

The psychologists rated individuals exhibiting symptoms of Antisocial Personality Disorder and Alcohol Abuse as being significantly more responsible for their behaviour than those exhibiting symptoms of anxiety and depression. Psychotherapy was rated as most useful for anxious and depressed persons, less useful for alcohol abusers, and least useful for people with Antisocial Personality Disorder. Ratings of the usefulness of drugs, in descending order, were for: Major Depression, Generalized Anxiety Disorder, Alcohol Abuse, and Antisocial Personality Disorder.

#### Sex of Subject Effects

Sex of Subject effects were found for ratings of the usefulness of drugs and for ratings of prognosis.

The mean drug usefulness rating (on a 7-point scale) given by male psychologists was 3.39 and the mean drug usefulness rating given by



female psychologists was 2.80,  $F(1,75) = 8.22$ ,  $p < .01$ . For prognosis, the mean rating given by female psychologists was 2.72 and the mean rating given by male psychologists was 3.18,  $F(1,75) = 7.77$ ,  $p < .01$ . These results indicated that male psychologists rated drugs as significantly more useful than did female psychologists, and that female psychologists predicted more optimistic outcomes than did male psychologists.

#### Sex of Subject by Type of Disorder Effects

Sex of Subject by Type of Disorder interaction effects were found for ratings of difference from the "average" person ( $F[3,225] = 3.88$ ,  $p < .01$ ) and for ratings of the usefulness of drug therapy ( $F[3,224] = 3.76$ ,  $p < .05$ ).

Female psychologists rated depressed, alcohol abusing and antisocial individuals as more different from the average than did male psychologists; while male psychologists rated anxious individuals as more different. In ratings of the usefulness of drugs, the mean scores of the male psychologists were higher than those of the female psychologists. However, depending on diagnosis, the discrepancies varied in size. Drug usefulness ratings of female and male psychologists were most similar for depressed and antisocial cases (highest and lowest ratings, respectively), and least similar for alcoholic and anxious cases (intermediate ratings).

#### Sex of Patient by Type of Disorder Effect

A Sex of Patient by Type of Disorder interaction effect was found for the psychologists' ratings of psychological disturbance (see Figure 1),  $F(3,225) = 5.93$ ,  $p < .0001$ .

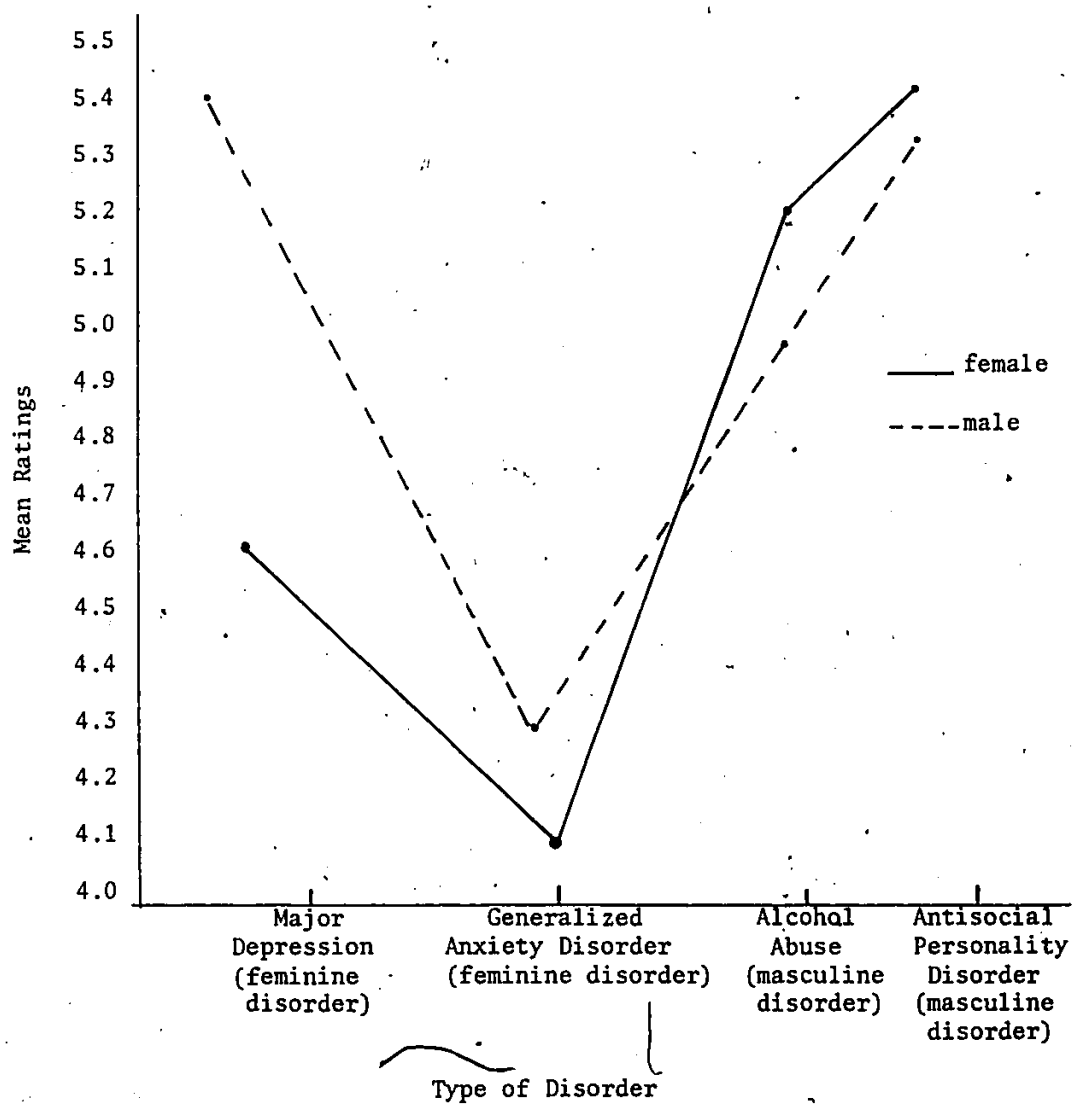


Figure 1. Mean ratings of psychological disturbance according to sex of patient and type of disorder (psychologist sample)

As Figure 1 indicates, depressed and anxious males were rated as more severely disturbed than their female counterparts, while antisocial and alcohol abusing females were rated as more severely disturbed than their male counterparts. Using Rosenfield's classifications of masculine and feminine disorders, the results can be summarized as follows: The masculine disorders were rated as more disturbed overall than the feminine disorders, with the high Antisocial Personality Disorder and low Generalized Anxiety Disorder ratings accounting for most of the difference. In addition, a higher rating of psychological disturbance was given when a disorder represented a sex-role deviation than when it did not.

#### Demographic Variables

Demographic variables of the psychologists which were noted included age and country of birth. A negative correlation ( $r = -.207$ ,  $p < .001$ ) was found between age and ratings of responsibility. A significant difference was found between North Americans' and non-North Americans' ratings of psychological disturbance, with the latter being higher,  $F(1,74) = 4.83$ ,  $p < .05$ .

#### Student Sample

Seven ANOVAs were computed, one for each dependent variable assessed by the questionnaires. These were 4 (Type of Disorder) x 3 (Sex of Patient) x 2 (Sex of Subject) ANOVAs, with Type of Disorder as a within-subjects factor. The results of these ANOVAs are summarized in Table 3.

Table 3

Summary of Significant Analyses of Variance Results for the StudentSample

Dependent variable	Source of variation	df	F
Ratings of psychological disturbance	Diag <sup>a</sup>	(3,438)	16.56**
	Sex S x Diag <sup>b</sup>	(3,438)	4.46**
Ratings of appropriate treatment	Sex S <sup>c</sup>	(1,146)	5.54*
	Diag	(3,437)	28.95**
	Sex P x Diag <sup>d</sup>	(6,437)	2.55*
Ratings of difference from the average person	Sex P <sup>e</sup>	(2,146)	3.35†
	Diag	(3,438)	15.09**
Ratings of prognosis	Diag	(3,438)	43.27**
Ratings of responsibility	Diag	(3,438)	17.56**
Ratings of usefulness of drug therapy	Diag	(3,438)	11.13**
Ratings of usefulness of psychotherapy	Diag	(3,437)	6.60**
	Sex S x Diag	(3,437)	2.75*

<sup>a</sup>Diag refers to the Type of Disorder effect

<sup>b</sup>Sex S x Diag refers to the Sex of Subject by Type of Disorder interaction effect

<sup>c</sup>Sex S refers to the Sex of Subject effect

<sup>d</sup>Sex P x Diag refers to the Sex of Patient by Type of Disorder interaction effect

<sup>e</sup>Sex P refers to the Sex of Patient effect

\*  $p < .05$

\*\* $p < .01$

### Type of Disorder Effects

Type of Disorder effects were found for all seven dependent variables. They can be summarized as follows: for ratings of psychological disturbance  $F(3,438) = 16.56, p < .0005$ ; for ratings of appropriate treatment  $F(3,437) = 28.95, p < .0005$ ; for ratings of difference from the "average" person  $F(3,438) = 15.09, p < .0005$ ; for ratings of prognosis  $F(3,438) = 43.27, p < .0005$ ; for ratings of responsibility  $F(3,438) = 17.56, p < .0005$ ; for ratings of the usefulness of psychotherapy  $F(3,437) = 6.60, p < .0005$ ; and for ratings of the usefulness of drug therapy  $F(3,438) = 11.13, p < .0005$ . Mean ratings of the seven variables for the four diagnoses are presented in Table 4, along with t-test results.

Inspection of Table 4 reveals that depressed and antisocial persons were rated as most psychologically disturbed, followed by alcohol abusing and anxious individuals, respectively. Depressed and antisocial individuals were also rated as most different from the average person, again followed by alcoholic and anxious individuals. The prognosis ratings for people with Antisocial Personality Disorders were significantly more pessimistic than those given for the other three disorders. Treatment recommendation scores indicated that the most intensive interventions were recommended for alcohol abusers and the least intensive were recommended for anxious people.

The alcohol abuser was rated as being most responsible for his or her behavior and the depressed person as least responsible. The responsibility ratings given for individuals with Antisocial Personality Disorder and Generalized Anxiety Disorder were significantly lower than those given for the alcohol abusers. The responsibility ratings given

Table 4

## Mean Student Questionnaire Ratings According to Type of Disorder (N=608)

Type of disorder	Ratings						
	Disturbance	Treatment	Difference	Prognosis*	Responsibility	Drug therapy	Psycho-therapy
Major depression	5.08 <sup>A</sup>	3.64 <sup>B</sup>	4.87 <sup>B</sup>	2.28 <sup>B</sup>	3.91 <sup>C</sup>	2.63 <sup>A</sup>	5.07 <sup>A</sup>
Antisocial personality disorder	4.87 <sup>A</sup>	3.75 <sup>B</sup>	5.10 <sup>A</sup>	3.47 <sup>A</sup>	4.39 <sup>B</sup>	1.96 <sup>C</sup>	4.73 <sup>B</sup>
Alcohol abuse	4.56 <sup>B</sup>	4.00 <sup>A</sup>	4.80 <sup>B</sup>	2.30 <sup>B</sup>	5.06 <sup>A</sup>	2.45 <sup>B</sup>	4.68 <sup>B</sup>
Generalized anxiety disorder	4.15 <sup>C</sup>	3.15 <sup>C</sup>	4.21 <sup>C</sup>	2.45 <sup>B</sup>	4.14 <sup>B</sup>	2.80 <sup>A</sup>	4.41 <sup>C</sup>

Note. Means with the same letter are not significantly different from each other at the .05 level. "A" is the highest mean, "B" the second highest, "C" the third highest, and "D" the lowest.

\* The lower the prognosis score, the more optimistic is the prognosis.

for people with Antisocial Personality Disorder were significantly higher than the ratings given for depressed people. Psychotherapy was rated as most useful for depressed individuals and least useful for anxious individuals. Drugs were rated as most useful for anxious people and least so for people with Antisocial Personality Disorder.

#### Sex of Subject Effect

A Sex of Subject effect was found for ratings of appropriate treatment, with female students recommending more intervention than male students  $F(1,145) = 5.54, p < .02$ .

#### Sex of Patient Effect

A significant Sex of Patient effect was found for students' ratings of difference from the "average" person,  $F(2,146) = 3.35, p < .05$ . Males were rated as more different than females from the "average" person.

#### Sex of Subject by Type of Disorder Effects

A Sex of Subject by Type of Disorder effect was found for ratings of psychological disturbance,  $F(3,438) = 4.46, p < .01$ . Female students gave higher mean ratings of disturbance for all types of disorder except Major Depression, for which males' ratings were higher. A Sex of Subject by Type of Disorder effect was also found for ratings of the usefulness of psychotherapy,  $F(3,437) = 2.75, p < .05$ . Again, females gave higher mean ratings for all types of disorder except Major Depression. Male students rated psychotherapy as more useful for Major Depression than did female students.

### Sex of Patient by Type of Disorder Effect

A Sex of Patient by Type of Disorder interaction effect was found for treatment recommendation ratings,  $F(6,437) = 2.55$ ,  $p < .02$ . For Antisocial Personality Disorder and Alcohol Abuse, most intervention was recommended for the sex-unspecified cases, less for the female cases and least for the male cases. More intensive treatment was recommended for depressed males than for depressed sex-unspecified and female cases. The treatment recommendations for depressed females were the least intensive. For Generalized Anxiety Disorder, more intensive treatment was recommended for females than for males or sex-unspecified cases. Sex-unspecified cases received the least intensive recommendations.

### Chi-square Analysis of Gender Guessing

The student group which rated the sex-unspecified cases had also been asked to guess the gender of the individuals in the case histories. Chi-square tests revealed no significant association of Sex of Subject with guessing. It did reveal a highly significant ( $p < .0001$ ) association between Type of Disorder and guessing. Consistent with Rosenfield's classification system, depressed and anxious individuals were more likely to be thought female than male; the reverse was true for Antisocial Personality Disorder and alcohol abusing individuals.

### Demographic Variables

The demographic variables which were obtained from the students were age, major subject, year of study, and country of birth. Age was not significantly correlated with any of the seven ratings. Year of study was significantly related to ratings of responsibility,  $F(3,129) = 4.13$ ,  $p < .01$ . Students in third and fourth year rated patients as more



responsible for their behavior than did students in earlier years. There was a significant place of birth effect on ratings of drug usefulness ( $F(1,129) = 11.52, p < .001$ ), with non-North Americans rating drug therapy more useful than North Americans rated it. Non-North Americans gave higher ratings of psychological disturbance than did North Americans,  $F(1,129) = 4.85, p < .03$ . Social science students gave higher ratings of difference from the "average" person than did non-social science students,  $F(1,129) = 9.36, p < .003$ .

## CHAPTER IV

### DISCUSSION

The main purpose of the present study was to compare the reactions of both clinicians and laymen to case vignettes describing men and women with symptoms of Major Depression, Generalized Anxiety Disorder, Antisocial Personality Disorder, and Alcohol Abuse. Some of the results of this study support the idea that perceptions of mentally ill people are influenced by the degree to which the patient deviates from his or her sex-role norms. Additional findings indicate that the sex of and professional status (clinical psychologist or undergraduate) of subjects are also related to their perceptions of patients and their treatment recommendations.

#### Rosenfield's Hypothesis

As stated earlier, Rosenfield's (1982) position is that reactions to mental illness are influenced by the degree to which the mentally ill individual deviates from his or her wider sex-role norms. The significant Sex of Patient by Type of Disorder interaction effect found for psychologists' ratings of psychological disturbance indeed would seem to support this view. Alcohol Abuse and Antisocial Personality Disorder (the "masculine disorders") were rated as more severe psychological disturbances when they occurred in women. Similarly, Major Depression and Generalized Anxiety Disorder (the "feminine disorders") were rated as more severe when they occurred in men. This Sex of Patient by Type of Disorder effect was not found for the

students' ratings of psychological disturbance. Perhaps their youth accounts for this difference, since they are more likely to have been raised with less clear-cut sex-role norms than the (older) psychologists and have had less time for such norms to become firmly entrenched. As well, there is less concern with sex-role expectations in university settings than in many others. Another possible explanation of the finding is that the training and/or clinical experience of the psychologists has resulted in their viewing male and female patients with "gender-linked" disorders differently. Repeating the study with control groups of younger psychologists (or psychology graduate students) or older laypeople would help to explain the differing student and psychologist results.

Although no significant Sex of Patient by Type of Disorder effect was found for students' ratings of psychological disturbance, such an effect was revealed for their treatment recommendations. Results were in the direction predicted by Rosenfield's hypothesis for patients with Antisocial Personality Disorder, Alcohol Abuse, and Major Depression. In the first two cases more intervention was recommended for females than males, while in the latter case more intervention was recommended for males. Contrary to Rosenfield's hypothesis, more intensive treatment was recommended for females with Generalized Anxiety Disorder than for males with this disorder. These results suggest that a patient's deviation from sex-role norms does influence the students' decisions regarding appropriate treatment. However, the trend predicted by Rosenfield's hypothesis was consistently present only for the "masculine disorders." The significant Sex of Patient by Type of Disorder effect for psychologists' ratings of psychological disturbance

was considerably larger and more consistent with Rosenfield's hypothesis than the Sex of Patient by Type of Disorder effect for students' ratings of treatment.

The student group given the sex-unspecified cases was asked to guess the gender of the persons described. A significant Type of Disorder association was found; this was in the direction predicted by Rosenfield's classification of masculine and feminine disorders. Case histories of Alcohol Abuse and Antisocial Personality Disorder were much more often thought to be describing men, while case histories of Major Depression and Generalized Anxiety Disorder were much more often thought to be describing women. This result suggests that the sex-role aspect of these mental disorders is salient to students as well as to psychologists. However, unlike the psychologists, the students, when presented with specific cases of males and females, did not judge them to be more disturbed if the disorder was incongruent with the patient's sex-role norms. However, a significant Sex of Patient effect for ratings of difference from the "average" person was found for the student group, which suggests that mental illness may be viewed by them as more deviant in men than in women.

#### Differences Between the Psychologist and Student Samples

While Antisocial Personality Disorder was seen as very severe and Generalized Anxiety Disorder as relatively non-severe by both groups, as represented by their ratings of psychological disturbance, difference from the "average" person and prognosis, Major Depression appeared to be viewed quite differently by the two groups. The psychologists' ratings of the depressed patients on the scales most related to severity

(psychological disturbance, difference from the "average" person and prognosis scales) were very similar to their ratings of anxious patients, while those of the students were very similar to the students' ratings of the Antisocial Personality Disordered patients. Perhaps the clinical experience of the psychologists has contributed greatly to this difference between the two groups; more specifically, it is likely that most psychologists had come into contact with some depressed patients, since depression is one of the most common emotional disturbances. Therefore, they would likely be less alarmed than laymen by symptoms such as suicidal wishes, which they would tend to see in the context of other symptoms which result from the dynamics of depression.

Sex of Subject by Type of Disorder effects for ratings of psychological disturbance and usefulness of psychotherapy were found for students, but not psychologists. Female students generally rated patients as more disturbed and psychotherapy as more useful than did male students. However, males rated Major Depression as a more severe psychological disturbance than did females, and they also rated psychotherapy as more useful for it. Perhaps the ratings of greater psychological disturbance and greater usefulness of psychotherapy which were given by females for three of the four disorders are a reflection of their greater willingness to acknowledge emotional distress and seek help for it. It could also reflect a narrower definition of normalcy. Female students also gave higher treatment recommendation ratings than male students; this result is compatible with either hypothesis. It is not surprising that this result did not appear in the psychologist sample; male psychologists, by virtue of their choice of career and training, would be expected to acknowledge emotional distress and seek help when

necessary. It is possible that the higher ratings of psychological disturbance and psychotherapy usefulness given by male students for Major Depression cases are a reaction to depression as a feminine response to problems; that is, a response which the male student would find quite alarming in himself. Perhaps the Sex of Subject by Type of Disorder effect for ratings of difference from the "average" person found in the psychologist sample can be explained by a similar phenomenon. Female psychologists rated depressed, Antisocial Personality Disorder and alcohol abusing patients as more different from the average than did male psychologists. Male psychologists gave higher ratings of difference than female psychologists for anxious patients. One can speculate that female psychologists view anxiety symptoms as less different because they are more acceptable, and perhaps more common, among women.

Two differences between the psychologist and student samples may simply reflect more clinical knowledge of the former. Students recommended psychotherapy more for Antisocial Personality Disorder cases than for Generalized Anxiety Disorder cases, while psychologists did the reverse. In many clinical psychology textbooks psychotherapy is presented as a very ineffective treatment for Antisocial Personality Disorder (psychopathy). The psychopath's lack of remorse and anxiety contribute to his/her being a difficult psychotherapy client. Students and psychologists may have quite different characteristics in mind when they consider the appropriateness of a person for psychotherapy. One can speculate that students might rate cleverness as a very important characteristic, while psychologists might view the presence of some degree of emotional discomfort as fairly important. While both groups gave the Antisocial Personality Disorder cases the most pessimistic

prognosis, their prognosis ratings for the three other disorders suggested that the psychologists' ratings were based on more precise knowledge of treatment outcomes. The students' prognosis ratings for the Alcohol Abuse, Major Depression and Generalized Anxiety Disorder cases were not significantly different from one another, while the psychologists' ratings were more differentiated. From most to least optimistic were their ratings of the Generalized Anxiety Disorder, Major Depression, Alcohol Abuse and Antisocial Personality Disorder cases.

#### Sex of Subject Effects in the Psychologist Sample

Two unpredicted differences between male and female psychologists were found. Male psychologists gave significantly higher drug usefulness ratings. Drugs were rated most useful for Major Depression patients and least so for Antisocial Personality Disorder patients. The Sex of Subject (psychologist) differences were most pronounced for the Alcohol Abuse and Generalized Anxiety Disorder cases. Perhaps the sex difference indicates that male psychologists have a stronger belief in biochemical bases of emotional disturbance. In addition, female psychologists may be more concerned with the potential abuses of psychoactive medication, which have affected more female than male patients in the past.

The second unpredicted sex difference for psychologists was in their prognosis ratings. Female psychologists gave significantly more optimistic prognoses than male psychologists gave. This finding may have interesting treatment implications; however, it is not possible to deduce the nature of such implications based on the present study. The different prognosis ratings given by male and female psychologists may

be related to the different drug usefulness ratings, and may suggest that male and female psychologists to some extent hold different views of psychopathology. A disease model of psychopathology would more likely lead to a recommendation for drug therapy than would a model in which psychopathology is viewed as a developmentally natural reaction to unsatisfactory life circumstances. In the latter model psychopathology would tend to be seen as a transition phase between an old and new organization of a person's thoughts, feelings and behaviours. Perhaps psychologists who hold this model would generally be more optimistic regarding their clients' futures than would psychologists holding a disease model. One can speculate that the disease model is more prevalent among male clinicians sampled in the present study, while the developmental model is more prevalent among the female clinicians sampled.

#### Demographic Variables

In both the psychologist and student samples non-North Americans gave significantly higher psychological disturbance ratings than did North Americans. It would be interesting to know what cultural factors contributed to these findings. Perhaps the psychological disorders presented in the case histories are more common in North America than in the non-North American subjects' countries of origin.

Social Science students gave higher "difference" ratings than non-Social Science students. One could speculate that Social Science students are attuned to human behavior more than many students in other programs are, and that they are, therefore, more sensitive to deviations. Social Science students and non-North American students rated drugs as



more useful for the patients than non-Social Science and North American students did.

A significant negative correlation between age and ratings of responsibility was found for the psychologist sample. The word "responsibility" may have been interpreted differently by different subjects, but perhaps this finding represents a tendency to become less judgmental with increasing age and clinical experience, as one becomes more aware of the conditions which contribute to unusual behavior. In contrast, students in their third and fourth years of university gave higher "responsibility" ratings than those in their first and second years. Perhaps as the students become more separated from their families of origin, they begin to see themselves and others as more responsible for themselves and their behavior.

#### Summary

Rosenfield's hypothesis was supported by the finding of a significant Sex of Patient by Type of Disorder interaction effect for psychologists' ratings of psychological disturbance. Males with "feminine" disorders (Generalized Anxiety Disorder and Major Depression) and females with "masculine" disorders (Alcohol Abuse and Antisocial Personality Disorder) were rated as more psychologically disturbed than their opposite sex counterparts. A finding consistent with Rosenfield's classification of masculine and feminine disorders was the significant Type of Disorder effect on students' guesses of sex-unspecified patients' genders. Sex-unspecified patients with Generalized Anxiety Disorder and Major Depression were more often guessed to be female, and patients exhibiting symptoms of Alcohol Abuse and Antisocial Personality Disorder were more

often guessed to be male.

Several differences between the student and psychologist samples were examined. Some may reflect differences in attitudes towards sex roles, while others may result from differences in exposure to patients such as those described in the vignettes.

Two Sex of Subject effects in the psychologist sample were explored. Male psychologists rated drug therapy as more useful than female psychologists did. Female psychologists' ratings of patients' prognoses were significantly more optimistic than male psychologists' ratings. These differences may reflect differences in the ways male and female psychologists view psychopathology in general.

APPENDIX A  
CASE HISTORIES

## Alcohol Abuse

## Male Case:

Mr. C. is a 40-year-old married man. For the past eight months he has been consuming large amounts of liquor. He cannot start the day or go to a party without drinking. He has often had blackouts from his drinking episodes. Several times he has attempted to reduce his drinking by restricting it to weekends, but his efforts have failed. He feels he is a victim of his impulse to drink and believes he "can't help it."

Mr. C's drinking has led to numerous arguments with his family and friends, who find him obnoxious when drunk. In addition, he has missed many days of work and is in danger of being fired.

## Alcohol Abuse

## Female Case:

Mrs. C. is a 40-year-old married woman. For the past eight months she has been consuming large amounts of liquor. She cannot start the day or go to a party without drinking. She has often had blackouts from her drinking episodes. Several times she has attempted to reduce her drinking by restricting it to weekends, but her efforts have failed. She feels she is a victim of her impulse to drink and believes she "can't help it."

Mrs. C's drinking has led to numerous arguments with her family and friends, who find her obnoxious when drunk. In addition, she has missed many days of work and is in danger of being fired.

## Alcohol Abuse

## Sex-unspecified Case:

Person C. is 40 years old and married. For the past eight months this person has been consuming large amounts of liquor. C. cannot start the day or go to a party without drinking, and has often had blackouts as a result of drinking episodes. Several times this individual has attempted to reduce the drinking by restricting it to weekends, but such efforts have failed. C. feels like a victim of the impulse to drink and feels helpless to change the situation.

Person C's drinking has led to numerous arguments with family and friends, who find C. obnoxious when drunk. In addition, C. has missed many days of work and is in danger of being fired.

## Antisocial Personality Disorder

## Male Case:

Mr. B. is 25 years old. In his early teens he was suspended from school for misbehavior and truancy. Psychological testing (IQ tests) carried out by the school revealed that his academic performance was far inferior to that which he was capable of. He dropped out of school at age 16.

Since his departure from school Mr. B. has been unable to keep a job for very long and has been unemployed for extended periods of time. He has also been unable to maintain enduring romantic relationships or friendships.

People who know Mr. B. describe him as insincere, glib and deceitful. He has repeatedly been in trouble with the law for "conning" people. Mr. B. is an impulsive, egocentric person whose behavior is guided by the desire for immediate and tangible gain. He appears to be deficient of conscience, unable to understand the significance of his violations of others' rights and unable to express his feelings.

## Antisocial Personality Disorder

## Female Case:

Ms. B. is 25 years old. In her early teens she was suspended from school for misbehavior and truancy. Psychological testing (IQ tests) carried out by the school revealed that her academic performance was far inferior to that which she was capable of. She dropped out of school at age 16.

Since her departure from school Ms. B. has been unable to keep a job for very long and has been unemployed for extended periods of time. She has also been unable to maintain enduring romantic relationships or friendships.

People who know Ms. B. describe her as insincere, glib and deceitful. She has repeatedly been in trouble with the law for "conning" people. Ms. B. is an impulsive, egocentric person whose behavior is guided by the desire for immediate and tangible gain. She appears to be deficient of conscience, unable to understand the significance of her violations of others' rights and unable to express her feelings.



## Antisocial Personality Disorder

## Sex-unspecified Case:

Person B. is 25 years old. When a young teenager, this person was suspended from school for misbehavior and truancy. Psychological testing (IQ tests) carried out by the school revealed that B's academic performance was far inferior to that which B. was capable of. At age 16 B. dropped out of school.

Since departing from school, B. has been unable to keep a job for very long and has been unemployed for extended periods of time. B. also has been unable to maintain enduring romantic relationships or friendships.

People who know B. describe this person as insincere, glib and deceitful. B. has repeatedly been in trouble with the law for "conning" people. B. is an impulsive, egocentric person whose behavior is guided by the desire for immediate and tangible gain. B. appears to be deficient of conscience, unable to understand the significance of violations of others' rights and unable to express feelings.

### Generalized Anxiety Disorder

#### Male Case:

For the past few months Mr. D., a 35-year-old man, has been experiencing persistent anxiety. He feels jittery and restless much of the time. He complains of discomfort in the pit of his stomach, a pounding, racing heart, and sweaty palms. He has trouble sleeping and concentrating, and has been more irritable than usual. As well, he worries much of the time, brooding over minor matters and anticipating future misfortunes. He cannot pinpoint a specific thing which is wrong, but is preoccupied with his own feelings.

## Generalized Anxiety Disorder

### Female Case:

For the past few months Ms. D., a 35-year-old woman, has been experiencing persistent anxiety. She feels jittery and restless much of the time. She complains of discomfort in the pit of her stomach, a pounding, racing heart, and sweaty palms. She has trouble sleeping and concentrating, and has been more irritable than usual. As well, she worries much of the time, brooding over minor matters and anticipating future misfortunes. She cannot pinpoint a specific thing which is wrong, but is preoccupied with her own feelings.

## Generalized Anxiety Disorder

## Sex-unspecified Case:

For the past few months, Person D., who is 35 years old, has been experiencing persistent anxiety. D. feels jittery and restless much of the time, and complains of discomfort in the pit of the stomach, a pounding, racing heart, and sweaty palms. D. has trouble sleeping and concentrating, and has been more irritable than usual. As well, D. worries much of the time, brooding over minor matters and anticipating future misfortunes. D. cannot pinpoint a specific thing which is wrong, but is preoccupied with the feelings described above.

## Major Depression

## Male Case:

Mr. A. is 30 years old. In the past couple of months Mr. A. has been having much difficulty sleeping, and his appetite has decreased markedly. He feels fatigued and low in energy most of the time, and complains of being unable to concentrate or think clearly. Mr. A's interest in sex has almost totally disappeared.

Mr. A. feels worthless and sometimes wishes that he were dead. He has frequent crying spells, especially when alone. He has lost interest and pleasure in most of the activities that he used to enjoy. His mood is characterized by sadness, hopelessness and irritability.

## Major Depression

## Female Case:

Ms. A. is 30 years old. In the past couple of months Ms. A. has been having much difficulty sleeping and her appetite has decreased markedly. She feels fatigued and low in energy most of the time, and complains of being unable to concentrate or think clearly. Ms. A's interest in sex has almost totally disappeared.

Ms. A. feels worthless and sometimes wishes that she were dead. She has frequent crying spells, especially when alone. She has lost interest and pleasure in most of the activities that she used to enjoy. Her mood is characterized by sadness, hopelessness and irritability.

## Major Depression

## Sex-unspecified Case:

Person A. is 30 years old. In the past couple of months A. has been having much difficulty sleeping, and has noticed a marked decrease in appetite. A. feels fatigued and low in energy most of the time, and complains of being unable to concentrate or think clearly.

A's interest in sex has almost totally disappeared.

A. feels worthless and sometimes wishes to be dead. A. has frequent crying spells, especially when alone. A. has lost interest and pleasure in most activities that used to be enjoyable. A's mood is characterized by sadness, hopelessness and irritability.

APPENDIX B  
QUESTIONNAIRE



Your Age \_\_\_\_\_ Country of Birth \_\_\_\_\_ Sex \_\_\_\_\_

Year of Study (students) \_\_\_\_\_ Major Subject (students) \_\_\_\_\_

Based on the limited information you have been given in the above case history, please answer the following questions.

1. How psychologically disturbed do you think this individual is?

1 2 3 4 5 6 7

normal and  
well-adjusted

moderately  
disturbed

extremely  
disturbed

2. How responsible do you think this person is for the behavior described above?

1 2 3 4 5 6 7

not at all  
responsible

somewhat  
responsible

totally  
responsible

3. How different from the average person does this individual appear to be?

1 2 3 4 5 6 7

not at all  
different

moderately  
different

very  
different

4. Which of the following would you recommend as being most appropriate for this person?

1 2 3 4 5

Let him or  
her cope with  
these  
problems  
alone, rather  
than interfere.

Recommend  
that this  
person get  
some rest  
and enjoy a  
change of  
pace.

Recommend  
counseling  
from a  
clergyman or  
family  
doctor.

Recommend  
treatment  
from a  
professional  
psychologist  
or  
psychiatrist.

Recommend  
inpatient  
treatment  
in a  
hospital.

5. How useful do you think psychotherapy would be for this person?

1 2 3 4 5 6 7

not at all

somewhat

extremely

continues ...

6. How useful do you think drug therapy would be for this person?

1	2	3	4	5	6	7
not at all			somewhat			extremely

7. Which of the following outcomes do you think is most likely, assuming that this person receives appropriate and competent treatment?

1	2	3	4	5	6	7
total recovery			moderate improvement			no change

APPENDIX C  
LETTER TO PSYCHOLOGISTS

Dear Dr. \_\_\_\_\_:

I am a graduate student in the Clinical Psychology program at the University of Windsor. I am carrying out research for my Masters thesis and would appreciate your participation. This should take 10 to 15 minutes.

I have enclosed four anonymous but factual case histories, followed by a brief questionnaire. Although the information presented is, I realize, very limited, please answer the questions based on your impressions or past experience with these types of individuals.

If you would like a description of the purpose and results of my study, upon its completion, please send your name and address with your case histories and questionnaires in the enclosed envelope.

I appreciate your time and help very greatly, since I am dependent on the returned questionnaires for my thesis data.

Thank you,

JW/ld  
Encl.

Jodie Waisberg

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- 1976 Graduated from York Mills Collegiate Institute, Toronto  
Ontario
- 1981 Obtained B.Sc. (Zoology) from the University of Toronto,  
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- 1982 Entered the Graduate Psychology program in the clinical  
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